



National Center for Cultural Competence

*Georgetown University Child Development Center
Center for Child Health and Mental Health Policy
University Affiliated Program*

Getting Started ...

Planning, Implementing and Evaluating Culturally Competent
Service Delivery Systems in Primary Health Care Settings

Implications for Policy Makers and Administrators

This checklist was developed by the National Center for Cultural Competence (NCCC). It is designed to assist programs and organizations, concerned with the delivery of primary and community-based health care, to begin strategic development of policies, structures, procedures and practices that support cultural and linguistic competence. It is also designed to support the campaign launched by the Bureau of Primary Health Care, "Zero Percent Disparities and One Hundred Percent Access". Nationally, health care programs and organizations are struggling with the challenges and opportunities to respond effectively to the needs of individuals and families from racially, ethnically, culturally and linguistically diverse groups. There is no one method for getting started on the journey towards cultural competence — at either the individual or program/organizational level. Individuals and programs/organizations may embark on this journey at different points of departure with different estimated times of arrival for achieving specific goals and outcomes. Most health and human service organizations and their personnel are at various levels of awareness and stages along the cultural competence continuum. Few programs or organizations have evolved to a degree of proficiency in which they systematically incorporate culturally competent principles and practices at all levels—including the policy making, administrative, practice/service delivery and consumer levels. This checklist provides some guidance for **getting started**.



Tawara D. Goode - National Center for Cultural Competence
3307 M Street, NW, Suite 401, Washington, D.C. 20007-3935
202-687-5387 ■ 800-788-2066 (voice) ■ 202-687-8899 (fax) ■ cultural@gunet.georgetown.edu (E-mail)
Website <<http://www.dml.georgetown.edu/depts/pediatrics/gucdc>>



National Center for Cultural Competence

*Georgetown University Child Development Center
University Center for Excellence in Developmental Disabilities*

WINTER 2002

A Guide to...

Planning and Implementing Cultural Competence Organizational Self-Assessment

Rationale for Self-Assessment

Health and human service organizations are recognizing the need to enhance services for culturally and linguistically diverse populations. Assessing attitudes, practices, policies and structures of administrators and service providers is a necessary, effective and systematic way to plan for and incorporate cultural competence within an organization. Determining the needs, preferences and satisfaction of family members/consumers is an essential aspect of this process. The Maternal and Child Health Bureau (MCHB), through its Title V–Children With Special Health Care Needs programs (CSHCN), supports self-assessment as a tool that assists with the development of State Block Grant applications. The MCHB also emphasizes self-assessment as a key strategy to address Goal III, Objective 3.9—To increase the percentage of states that implement culturally competent policies, practices and procedures to 100%.

Essential Elements in Achieving Cultural Competence

The National Center for Cultural Competence (NCCC) embraces a conceptual framework and model for achieving cultural competence adapted from the work of Cross et al., 1989. Cultural competence requires that organizations and their personnel have the capacity to: (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to the diversity and cultural contexts of the individuals and communities served. Consistent with this framework, a major focus of the NCCC is the provision of technical assistance to conduct self-assessment within health care and human service agencies. The focus includes the development of assessment instruments and processes for both organizations and individuals.

The Benefits of Self-Assessment

The NCCC supports the concept that cultural competence is a developmental process and evolves over an extended period. Both organizations and individuals are at various levels of awareness, knowledge and skill acquisition along the cultural competence continuum. The capacity to engage in self-assessment helps organizations to:

- gauge the degree to which they are effectively addressing the needs and preferences of culturally and linguistically diverse groups;
- establish partnerships that will meaningfully involve families/consumers and key community stakeholders;

Tawara D. Goode, Wendy Jones & James Mason
National Center for Cultural Competence

3307 M Street, NW, Suite 401, Washington, DC 20007-3935
Voice: 800-788-2066 or 202-687-5387 • TTY: (202) 687-5503 • Fax: 202-687-8899
E-mail: cultural@georgetown.edu • URL: <http://gucdc.georgetown.edu/nccc>



- improve family/consumer access to and utilization of services and enabling supports;
- increase family/consumer satisfaction with services received;
- strategically plan for the systematic incorporation of culturally and linguistically competent policies, structures and practices;
- allocate personnel and fiscal resources to enhance the delivery of services and enabling supports that are culturally and linguistically competent; and
- determine individual and collective strengths and areas for growth.

There are numerous benefits to self-assessment. Such processes can lead to the development of a strategic organizational plan with clearly defined short-term and long-term goals, measurable objectives, identified fiscal and personnel resources, and enhanced consumer and community partnerships. Self-assessment can also provide a vehicle to measure outcomes for personnel, organizations, population groups and the community at large. The NCCC views self-assessment as an ongoing process, not a one-time occurrence. It offers organizations and their personnel the opportunity to assess individual and collective progress over time.

The NCCC's Values and Guiding Principles of Self-Assessment

The NCCC uses a set of values and principles to guide all of its self-assessment activities including the development of knowledge and products, dissemination, and the provision of technical assistance and consultation.

- **Self-assessment is a strengths-based model.**

The purpose of self-assessment is to identify and promote growth among individuals and within organizations that enhances their ability to deliver culturally and linguistically competent services and supports. Self-assessment emphasizes the identification of strengths, as well as areas of growth, at all levels of an organization. The process also allows organizations to identify and acknowledge the internal strengths and assets of personnel that in many instances are inadvertently overlooked.

- **A safe and non-judgmental environment is essential to the self-assessment process.**

Self-assessment is most productive when conducted in an environment that: (1) offers participants a forum to give honest statements of their level of awareness, knowledge and skills related to cultural and linguistic competence; and (2) provides an opportunity for participants to share their individual perspectives in a candid manner; and (3) assures that information provided will be used to effect meaningful change within the organization. The NCCC embraces the concept that cultural competence is developmental and occurs along a continuum (Cross et. al.) It matters not where an individual or organization starts, as long as there is continued progression towards the positive end of the continuum.

- **A fundamental aspect of self-assessment assures the meaningful involvement of consumers, community stakeholders and key constituency groups.**

Principles of self-determination and cultural competence assure that consumers are integrally involved in processes to plan, deliver, and evaluate services they receive. These principles extend beyond the individual to the community as a whole. Self-assessment must solicit and value the experiences and perspectives of consumers and families who receive services. Similarly, opinions should be sought from key stakeholders and constituency groups within the broad integrated service delivery system. An inclusive self-assessment process can forge alliances and partnerships that have long-lasting benefit for the organization and the larger community.

■ **The results of self-assessment are used to enhance and build capacity.**

The intent of the self-assessment process is neither to render a score or rating nor to label an individual or an organization. Rather, it is intended to provide a snapshot as to where an individual or organization is at a particular point in time. Results should be used to strategically plan long- and short-term objectives to enhance the organization's capacity to deliver culturally and linguistically competent services at all levels within the organization, including: policy makers, administrators, providers, subcontractors and consumers at both the state and local level. The NCCC's experiences with self-assessment have demonstrated that comparisons between professionals and among organizations are of little benefit. Greater benefit is derived from individual and organizational self-comparison over extended periods of time to ascertain the extent to which growth has occurred.

■ **Diverse dissemination strategies are essential to the self-assessment process.**

Self-assessment results should be shared with participants and key stakeholders in a manner that meets their unique needs. The NCCC has employed an array of dissemination strategies that are tailored to the specific interests of the participating organization. This involves identification of the audiences and the presentation of the data in formats that are most useful and accessible. Additionally, this recognizes that the need for information will vary for policy makers, administrators, service providers, consumers and other stakeholders. Examples include but are not limited to:

- comprehensive reports and executive summaries
- Power Point presentations
- conference calls
- on-site program and workgroup consultations
- “Town Hall” style meetings, and
- strategic planning sessions.

The NCCC has provided linguistic and sign language interpretation services and translation of materials that respond to the needs of varied constituency groups. These strategies demonstrate an understanding of and respect for the diverse communication and learning styles among individuals and groups.

Useful Steps for Planning and Implementing Self-Assessment

The process of self-assessment is as important as the outcome. The NCCC has found the following steps to be very beneficial to the self-assessment processes it has conducted with seven State Title V MCH/CSHCN programs.

- **Cultivating Leadership.** It is incumbent upon leadership to establish a rationale for and to promote self-assessment as an organizational goal and priority. Cultivating leadership, in this instance, would encompass identifying members from all strata of an organization to fulfill leadership roles in the self-assessment process. “Effective leadership usually involves relinquishing or sharing power...at many levels” (Mahan, 1997). An emphasis should be placed on encouraging personnel to assume leadership roles at all levels of the organization. Shared power is an integral principle of leadership development (Kouzes & Posner, 1990; Covey, 1996; Melaville & Blank, 1991; Lipman-Blumen, 1996).
- **Getting “Buy-In”.** Establish a shared vision that conveys the importance of the self-assessment process to the overall organization, its personnel, the families/consumers and communities served. “Sharing a view of the future represents the most important context for effecting change” (Roberts & Magrab, 1999). When individuals are involved in the generation and use of knowledge... this enables different groups of people to act collectively based on informed decisions (Selener, 1990). A major benefit is the formation of a coalition of stakeholders, who are informed and prepared to affect and sustain change to improve the delivery of services and enabling supports.

- ☐ **Assuring Community Collaborations & Partnerships.** A major principle of cultural competence involves working in conjunction with natural, informal, support and helping networks within diverse communities (Cross et al., 1989). From the inception of the self-assessment process, include community partners and key stakeholders in meaningful ways. Some examples are developing a shared vision, identifying leadership roles and responsibilities, distributing tasks equitably based on capacity, and allocating resources. It is important to recognize that individuals and groups will choose different levels of involvement and ways to participate. This may vary from serving on task forces or workgroups, participation in focus groups, making in-kind or other fiscal contributions, sub-contracting for specific services to providing meeting facilities and other accommodations. It is essential to demonstrate that the contributions of each community partner are valued and respected.
- ☐ **Structuring Support for the Process.** Convene a committee, work group or task force that will assume responsibility for the self-assessment process. The group should have representation from policy making, administration, service delivery, consumers and other community stakeholders. It should also reflect the diversity of the organization and the community at large. This group is the primary entity for planning and implementing the self-assessment process, and should have ready access to decision makers or have the ability to make decisions.
- ☐ **Allocating Personnel and Fiscal Resources.** Conducting a self-assessment process is resource intensive. It requires a dedicated budget and level of effort for organizational personnel. This may also extend to community partners and key stakeholders involved in the process. Budgetary considerations may include subcontracts for the self-assessment process such as consultants/facilitators, meeting or conference facilities, and interpretation and translation services. There may be other associated costs for: stipends/honoraria for consumer participation and family supports; local/domestic travel reimbursement; and printing, mailing and other dissemination activities. Consideration should be given to the necessary level of effort for personnel who have responsibility for this process. This will entail delineating responsibilities and determining the duration and intensity of time required for personnel. It may require deferment or reassignment of current workload/duties. The self-assessment process depends on a well-crafted allocation of personnel and fiscal resources.
- ☐ **Managing Logistics.** The ability to effectively coordinate numerous logistical tasks is vital to the self-assessment process. The task force or workgroup needs to insure sufficient time to plan and prepare, timely dissemination of information to all involved and the development of a calendar and schedule of activities (e.g. sites and times for regular meetings, teleconferences, focus groups, administering the self-assessment instrument, data collection and analysis and dissemination of results).
- ☐ **Analyzing and Disseminating Data.** The active involvement of individuals, groups and communities is a highly valued and integral aspect of the self-assessment process. Task force and workgroup members need to plan their involvement in data collection (Census and program needs assessment data blended with the data from the self-assessment), analysis, interpretation, presentation and dissemination. This approach is commensurate with culturally competent and participatory action designs in research and evaluation (Brandt, 1999; Caldwell, et al, 1999; Goode & Harrison, 2000).
- ☐ **Taking the Next Steps.** The self-assessment process can yield a wealth of information about organizational strengths and areas for growth. Careful consideration should be given to:

 - establishing organizational priorities;
 - developing a strategic plan with goals and objectives to sustain strengths and address growth areas;
 - allocating necessary resources to accomplish strategic plan goals;
 - sustaining and maintaining partnerships with community stakeholders; and
 - incorporating self-assessment results into the state block grant planning and development process.

The self-assessment process may lead to changes in: organizational mission, policies, structures and procedures; staffing patterns; position descriptions and personnel performance measures; delivery of service and supports; outreach and dissemination approaches; composition of advisory boards and committees; professional development and inservice training activities; and management and information systems (MIS) and telecommunication systems. Achieving cultural competence is a long-term commitment. Remember that it is accomplished one step at a time.

References

- Brant, J. et al., *Oncology nursing society multicultural outcomes: Guidelines for cultural competence* (USA: The Oncology Press, 1999.)
- Caldwell, C., Jackson, K., Tucker, B., and Bowman, P. (In press). "Culturally Competent Research Methods in African American Communities: An Update." *Advances in African American Psychology: Theory, Paradigm Methodology, and Reviews*, ed. R.L. Jones. Hampton, VA: Cobb and Henry Publishers.
- Covey, S. (1996). Three roles of the leader in the new paradigm. *The leader of the future: New visions, strategies and practices for the new era*. In Hesselbein, F., Goldsmith, M., & Beckhard, R. (Ed.) San Francisco: Jossey-Bass.
- Cross, T., Bazron, B., Dennis, K., and Isaacs, M. (1989). *Towards a culturally competent system of care volume I*. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.
- Goode, T. & Harrison, S. (2000). *Policy brief 3: Cultural competence in primary health care: Partnerships for a research agenda*. Washington, D.C.: Georgetown University Child Development Center.
- Kouzes, J. M. & Posner, B.Z. (1990). *The leadership challenge*. San Francisco: Jossey-Bass.
- Lipman-Blumen, J. (1996). *The Connecting edge: Leading in an independent world*. San Francisco: Jossey-Bass.
- Magrab, P.R. (1999). The meaning of community. In Roberts, R. N. & Magrab, P.R. (Eds.), (pp. 3-29). *Where children live: Solutions for serving children and their families*. Stamford, CT: Ablex Publishing.
- Mahan, C. (1997). Surrendering control to the locals. *Journal of Public Health Management and Practice*, Vol. 3(1).
- Mason, J. (1996). *Cultural competence self-assessment questionnaire*. Portland, Oregon: JLM & Associates.
- Melaville, A. & Blank, M. (1991). *What it takes: Structuring interagency partnerships to connect children and families with comprehensive services*. Washington, D.C.: Education and Human Services Consortium.
- Selener, D. (1990). "Participatory Evaluation. People's knowledge as a source of power." *Networking Bulletin*.

About the

The mission of the National Center for Cultural Competence (NCCC) is to increase the capacity of health care and mental health programs to design, implement and evaluate culturally and linguistically competent service delivery systems. The NCCC conducts an array of activities to fulfill its mission including: (1) training, technical assistance and consultation; (2) networking, linkages and information exchange; and (3) knowledge and product development and dissemination. Major emphasis is placed on policy development, assistance in conducting cultural competence organizational self-assessments, and strategic approaches to the systematic incorporation of culturally competent values, policy, structures and practices within organizations.

The NCCC is a component of the Georgetown University Child Development Center and is housed within the Department of Pediatrics of the Georgetown University Medical Center. It is funded and operates under the auspices of Cooperative Agreement #U93-MC-00145-07 and is supported in part from the Maternal and Child Health program (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services.

The NCCC is a collaborative project between the Georgetown University Child Development Center and the following Federal government agencies:

Health Resources and Services Administration

- Maternal and Child Health Bureau (MCHB)
- Bureau of Primary Health Care (BPHC)
- Bureau of Health Professions (BHP)
- Office of Minority Health (OMH)

Department of Education

- Federal Interagency Coordinating Council (FICC)

Although the FICC project is not under the auspices of the Cooperative Agreement, the Statement of Work for this effort is directly related to increasing the capacity of Federal agencies and their funded programs and partners, to incorporate culturally competent policies and practices.

Permission is granted to reproduce this document for distribution. The only requirement is that proper credit be given to the National Center for Cultural Competence.

Suggested Citation:

Goode, T., Jones, W. and Mason, J. (2002). A guide to planning and implementing cultural competence organization self-assessment. Washington, D.C.: National Center for Cultural Competence, Georgetown University Child Development Center.

FOR ADDITIONAL INFORMATION CONTACT:

National Center for Cultural Competence
 Georgetown University Child Development Center
 3307 M St., NW, Suite 401 • Washington, DC 20007-3935
 Voice: 800-788-2066 or 202-687-5387
 TTY: 202-687-5503 • Fax: 202-687-8899
 E-mail: cultural@georgetown.edu
 Internet: <http://gucdc.georgetown.edu/nccc>

Notice of Nondiscrimination

In accordance with the requirements of Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, and Section 504 of the Rehabilitation Act of 1973, and implementing regulations promulgated under each of these federal statutes, Georgetown University does not discriminate in its programs, activities, or employment practices on the basis of the race, color, national origin, sex, age or disability. The University's compliance program under these statutes and regulations is supervised by Rosemary Kilkenny, Special Assistant to the President for Affirmative Action Programs. Her office is located in Room G-10, Darnall Hall, and her telephone number is (202) 687-4798.

- Convene a cultural competence committee, work group or task force within your program or organization. This group should have representation from policy making, administration, practice/service delivery and consumer levels and be reflective of the diversity within the program or organization and the community at large. The group can serve as the primary body for planning, implementing and evaluating organizational cultural competence initiatives.
- Ensure that your program or organization has a mission statement that commits to cultural competence as an integral component of all of its activities. The mission statement should articulate principles, rationale and values for culturally and linguistically competent health care service delivery. The cultural competence group should be involved in or facilitate the development of this statement.
- Determine the racially, ethnically, culturally and linguistically diverse groups within the geographic locale served by your program or organization. Assess the degree to which these groups are accessing services and the level of satisfaction with the services received.
- Determine the percentage of the population that resides in the geographic locale served by your program or organization affected by the six health disparities identified by HRSA. These include: cancer, cardiovascular disease, infant mortality, diabetes, HIV/AIDS, and child and adult immunizations. Collaborate with consumers, community-based organizations and informal networks of support to develop approaches for delivering preventive health messages in a culturally and linguistically competent manner. This collaborative process can help to inform your program or organization on adaptations to service delivery that respond to the needs and interests of diverse populations.
- Conduct a comprehensive program or organizational cultural competence self-assessment. Determine which instrument(s) and or consultant(s) best match the needs and interests of your program or organization. Use the self-assessment results to develop a long-term plan, with measurable goals and objectives, strategies and fiscal resources. This plan should allow for the incorporation of cultural and linguistic competence into all aspects of your program or organization. This may include, but is not limited to, changes in the following: mission statement, policies, procedures, program administration, staffing patterns, position descriptions, personnel performance measures, professional development, pre-service and inservice training activities, service delivery practices, approaches, for outreach, telecommunications and information dissemination systems, etc.
- Conduct an assessment of what program or organization personnel perceive as their staff development needs related to the provision of services to racially, ethnically, culturally and linguistically diverse groups.
- Convene focus groups or use other approaches to solicit consumer input on professional or staff development needs related to the provision of culturally and linguistically competent health care.
- Network and dialogue with other programs or organizations, concerned with primary and community-based health care, that have begun the journey towards developing, implementing and evaluating culturally competent service delivery systems. Adapt processes, policies and procedures and other information that are consistent with your program's or organization's needs and interests. Encourage partnerships and establish mechanisms to share training resources at the local, state or regional levels.

Tawara D. Goode - National Center for Cultural Competence
 3307 M Street, NW, Suite 401, Washington, D.C. 20007-3935
 202-687-5387 ■ 800-788-2066 (voice) ■ 202-687-8899 (fax) ■ cultural@gunet.georgetown.edu (E-mail)
 Website <<http://www.dml.georgetown.edu/depts/pediatrics/gucdc>>

- ☐ Aggressively pursue and utilize available resources from federally and privately funded technical assistance centers that have a mandate to catalog information on cultural and linguistic competence, primary health care, and health care issues specific to racially, ethnically, culturally and linguistically diverse groups (e.g. treatment, interventions, how to work with natural healers, outreach approaches, consumer education programs etc).
- ☐ Convene informal brown bag lunches or other forums to engage program or organization personnel in discussions and activities that offer an opportunity to explore attitudes, beliefs and values related to cultural diversity and cultural and linguistic competence.
- ☐ Identify and include budgetary expenditures each fiscal year for resource development and to facilitate professional development through their participation in conferences, workshops, colloquia and seminars on cultural and linguistic competence and other issues related to primary and community-based health care.
- ☐ Gather and categorize resource materials related to primary health care and culturally diverse groups for use as references by program or organization personnel.
- ☐ Build and utilize a network of natural helpers, community informants and other “experts” who have knowledge of the racially, ethnically, culturally and linguistically diverse groups served by your program or organization.
- ☐ Network with advocacy organizations concerned with specific health care, social and economic issues impacting racially, ethnically, culturally and linguistically diverse communities. Solicit their involvement and input in the design, implementation and evaluation of primary and community-based health care service delivery initiatives at the local, state, regional and national levels.

RESOURCES

Monographs

Building Cultural Competence: A Blueprint for Action (1995). Washington State Department of Health, Division of Community & Family Health.

Diversity Journal, (1997). Harvard Pilgrim Health Care, Inc., Brookline, MA

Websites

Health Care Rx: Access For All, The President's Initiative on Race.

Available: <http://www.hrsa.dhhs.gov/Newsroom/pubs.htm> [May 19, 1999]

Health Care Rx: Access For All, Boston Town Hall Meeting, July 10, 1998

<http://www.hrsa.dhhs.gov/Newsroom/features/Town%20Hall.htm> [May 19, 1999]

The Initiative to Eliminate Racial & Ethnic Disparities in Health

Available: <http://raceandhealth.hhs.gov> [May 7, 1999]

Minority Health is the Health of the Nation

Available: <http://www.cdc.gov/od/admh/window.htm> [May 7, 1999]

Office of Minority Health

Available: <http://www.hhs.gov/progorg/ophs/omh/cultural.htm> [May 7, 1999]

The Office of Minority and Women's Health

Available: http://www.bphc.hrsa.dhhs.gov/omwh/omwh_20.htm [May 18, 1999]



About the National Center for Cultural Competence

The National Center for Cultural Competence (NCCC) is a funded project of the Health Resources and Services Administration (HRSA). The project is a collaboration between: the Maternal and Child Health Bureau's (MCHB) Division of Services for Children With Special Health Needs and its Infant and Child Health Branch; and the Bureau of Primary Health Care (BPHC). The mission of the NCCC is to increase the capacity of health care programs to design, implement and evaluate culturally competent service delivery systems. The NCCC is focusing on HRSA funded programs including: 1) Maternal and Child Health Title V programs concerned with children with special health needs and their families; 2) primary health care programs such as Community Health Centers, Migrant Health Centers, Health Care for the Homeless Grantees, Healthy Schools, Healthy Communities Grantees, Primary Care Associations and Primary Care Offices; and 3) programs supporting families affected by Sudden Infant Death Syndrome and Other Infant Death.

The NCCC is a component of the Georgetown University Child Development Center, Center for Child Health and Mental Health Policy, and is housed within the Department of Pediatrics of the Georgetown University Medical Center. For additional information contact the NCCC as listed below.

Permission is granted to reproduce this document for distribution. The only requirement is that proper credit be given to the National Center for Cultural Competence and the author.

Tawara D. Goode - National Center for Cultural Competence

3307 M Street, NW, Suite 401, Washington, D.C. 20007-3935

202-687-5387 ■ 800-788-2066 (voice) ■ 202-687-8899 (fax) ■ cultural@gunet.georgetown.edu (E-mail)

Website <<http://www.dml.georgetown.edu/depts/pediatrics/gucdc>>



National
Center
for
Cultural
Competence

Policy Brief 4

GEORGETOWN UNIVERSITY CHILD DEVELOPMENT CENTER ■ UNIVERSITY CENTER FOR EXCELLENCE IN DEVELOPMENTAL DISABILITIES

Engaging Communities to Realize the Vision of One Hundred Percent Access and Zero Health Disparities: A Culturally Competent Approach

Introduction

The National Center for Cultural Competence publishes a Policy Brief series to facilitate the systematic incorporation of cultural and linguistic competence into organizational policy and structures. Policy Brief 4 is designed to provide health care organizations with the rationale for engaging communities in a culturally and linguistically competent manner. This brief provides guidance on prerequisite policies that serve as a foundation for infusing cultural and linguistic competence into community engagement.

Getting to Zero: Communities are Essential Partners

A Public Health Policy Imperative

A long-standing and well-documented pattern of health disparities exists in the United States. This pattern is apparent in health care outcomes and utilization and is evidenced by the disproportionate incidence of disease, disability and death among specific racial and ethnic groups. In response to this critical problem, the U.S. Department of Health and Human Services (DHHS) launched the Initiative to Eliminate Racial and Ethnic Disparities in Health in 1998. Six areas of health disparity were identified as priority targets for intervention: cancer screening and management; cardiovascular disease; diabetes; infant mortality; HIV / AIDS; and child and adult immunizations.

The initiative has been significantly strengthened by public health policy. Recent federal legislation specifically allocates resources for the study, prevention and treatment of health disparities among racial and ethnic groups (PL 106-525, Minority Health and Health Disparities Research and Education Act of 2000). The National Center on Minority Health and Health Disparities at the National Institutes of Health was established by this law. The elimination of health disparities is a key public policy focus of Healthy People 2010, the set of goals and objectives designed by the DHHS to assist the nation to achieve the vision of “*Healthy People in Healthy Communities*”. Healthy People 2010 states that “over the years, it has become clear that individual health is closely linked to community health...Likewise, community health is profoundly affected by the collective behaviors, attitudes and beliefs of everyone who lives in the community... Partnerships, particularly when they reach out to non-traditional partners, can be among the most effective tools for improving health in communities” (U.S. Department of Health and Human Services, 2000). Healthy People 2010 clearly articulates public health policy that recognizes the need to engage communities as essential partners in eliminating health disparities.

Responding to the Challenge

The Initiative to Eliminate Racial and Ethnic Disparities in Health has challenged the nation’s public health systems to create new approaches, including non-traditional partnerships, across diverse sectors of the community (Goode & Harrison, 2000; Davis et al., 1999; Mahan, 1997). The Health Resources and Services Administration’s Bureau of Primary Health Care (BPHC) continues to demonstrate leadership and innovation in response to this challenge. The BPHC is a national leader in delivering health care to underserved populations. Guided by a vision that everyone in the United States should have access to health care, the BPHC launched the

100% Access and 0 Health Disparities Campaign in 1999. This vision has been championed by Dr. Marilyn Gaston, Associate Administrator for Primary Health Care, who states “..that every person, in every underserved community will have access to primary and preventive care...and that there will be no disparities in health status due to race, ethnicity or income...” (Buluran, 2000). The *100% Access and 0 Health Disparities* has been accepted as a goal of the Health Resources and Services Administration.

The *100% Access and 0 Health Disparities* campaign is multifaceted and offers innovative approaches to create and maintain broad-based partnerships to achieve its goals. Dr. Gaston states, “We cannot achieve the vision alone... We need the help of every state, every national organization, every business, every academic institution and committed people from communities across the country “ (Buluran, 2000). The Center for Communities in Action is coordinating the BPHC’s effort to establish partnerships with 500 communities as a strategy to realize the vision of *100% Access and 0 Health Disparities*. The BPHC also developed a conceptual model that delineates a wide array of potential partners that have a vested interest in improving community health. According to the BPHC, “an integrated, primary care-based health system will emerge when a community declares its desired outcomes, engages its key partners and aligns its assets. The result will be healthier communities all across America” (Buluran, 2000).

Rationale for Cultural Competence in Community Engagement

■ *The complex nature of communities*

Establishing and sustaining broad-based community partnerships that embrace the vision of *100% Access and 0 Health Disparities* presents myriad benefits while simultaneously presenting unique challenges. One of the most fundamental challenges involves the complex nature of communities. Community is an elusive concept; it means different things to different people; and is defined differently in the literature for different purposes (Magrab, 1999). Several definitions of community follow.

Warren (1978) defines community as:

“a framework for living rather than as a political jurisdiction—a complex network of people, institutions, shared interests, locality, and a sense of psychological belonging”.

Webster’s Dictionary (1994) defines community as:

“an interacting population of various kinds of individuals in a common location; a body of persons of common interests scattered through a larger society; and joint ownership or participation”.

These definitions offer different perspectives and share a commonality that have particular relevance for community engagement efforts. They provide a framework from which to examine the variables that both benefit and challenge the process of engaging communities to achieve *100% Access and 0 Health Disparities*.

Community Diversity. The definition of community as *an interacting population of various kinds of individuals in a common location* addresses the challenges to community engagement posed by the growing diversity within U.S. communities. Reports from the Census Bureau indicate that the nation is more racially and ethnically diverse in the year 2000 than it was in 1990. Since 1990, diverse racial and ethnic groups have increased from approximately one-fourth to one-third of the U.S. population. This trend is expected to continue. The Census Bureau projects that in 2030, diverse racial and ethnic groups will comprise 40% (or two-fifths) of the total U.S. population.

Factors impacting community diversity involve more than race and ethnicity. Other factors include, but are not limited to, geographic location, population density, population stability, (e.g. rates of in-migration, out-migration, interstate migration, and immigration) (Campbell, 1996), the age distribution of population, social history, inter-group relationships, and the social, political and economic climates. Still other factors influence diversity among individuals and groups, such as language, nationality, acculturation, assimilation, age, gender, sexual orientation, education, literacy, socio-economic status, political affiliation, religious or spiritual beliefs and health beliefs and practices. A thorough understanding of these factors and respect for their

relevance are necessary for effective community engagement. Countless benefits can result when community diversity is acknowledged, valued and honored as an underpinning for partnerships to achieve *100% Access and 0 Health Disparities*.

Community Leadership. The definition of community as *a body of persons of common interests scattered through a larger society* suggests that challenges exist in increasing the number and capacity of community partners or key stakeholders to lead efforts for improved health. However, the leadership committed to eliminating health disparities should not rest solely within the domain of public health. Mahan, in *Surrendering Control to the Locals*, states “effective leadership usually involves relinquishing or sharing power... at many levels.” Shared power is an integral principle of leadership development and an essential element for community engagement (Kouzes & Posner, 1990; Covey, 1996; Melaville & Blank, 1991, Lipman-Blumen, 1996). The complex nature of this nation’s communities requires leadership approaches that are multifaceted and culturally competent. Such approaches must have the capability to engage diverse constituencies at multiple levels within any given community. Concerted efforts should be directed toward cultivating leadership in natural, informal, support and helping networks within communities. These efforts may include, but not be limited to, neighborhood, civic and advocacy associations; local/neighborhood merchants; local business alliance groups; ethnic, social, religious groups; faith-based organizations; spiritual leaders and healers; and ethnic and public interest media, etc. Research studies have demonstrated what many people know from experience—that feeling empowered to make a substantive contribution and to influence outcomes leads to a greater sense of satisfaction and improved performance (Kouzes & Posner, 1990). When others are strengthened and enabled to accomplish extraordinary things on their own, the original sphere of leadership is enhanced (Kouzes & Posner, 1990). “Nurturing leadership is as important as leadership itself” (Williams & Taylor, 1994). Cultivating and increasing leadership capacity is an indispensable strategy for engaging diverse communities in the goal to eliminate racial and ethnic disparity in health.

Community Investment. The definition of community as *joint ownership or participation* examines the challenges of soliciting and obtaining community investment and ownership for the health of all its members (Centers for Disease Control & Prevention, 1997). The social, political and economic climates of each community will present a different contextual reality for community engagement. Communities are often fraught with the problems of resource inequity among and between groups, politicalization, special interest factions, and entrenched ways of viewing and dealing with problems. Bringing about the shared vision of *100% Access and 0 Health Disparities* among such disparate community stakeholders is a daunting but essential endeavor. “Sharing a view of the future represents the most important context for community effectiveness. Vision encompasses the values, promise, and hope that energizes and amalgamates persons of diverse views and backgrounds to a common end” (Magrab, 1999).

Community investment in this vision will require health care organizations to:

- establish and maintain trust among community partners/members when there may be a history of adversarial relationships;
- effectively and equitably share limited resources among competing needs;
- share power and ensure that the contributions of community partners/members are valued and respected; and
- use varied communication modalities and technologies to provide community partners/members with full and timely access to information.

Achieving the visions of “Healthy People in Healthy Communities” and the elimination of health disparities require the capacity to engage individuals and groups in the community settings where they actually work, worship, play, learn and live.

■ *Community Solutions for Community Problems*

Research studies that include focus groups of community members often report findings about health beliefs and practices that otherwise, unknown and unattended, might undermine costly interventions. Several studies have found that many African-American men and women prefer to receive cancer screening services from their own physicians instead of screenings at clinics or health fairs. Until these African-American men and women were asked about their thoughts and beliefs, health care organizations knew only that their interventions and public health messages were not as effective in reaching this population (Williams, Abbott, Taylor, 1997 & Barber et al, 1998). Health care organizations cannot afford to ignore the expertise and solutions within the communities they serve. Two organizations that have exemplified culturally competent approaches to community engagement include Sunset Park Family Health Center in Brooklyn, New York and the Multnomah County Health Department in Portland, Oregon. See page 9 for additional listings and more information.

■ *Supporting the Economic Well Being of Communities*

The viability of any community is inextricably linked to the social-emotional, physical and economic well being of all of its members. Improving the health of individuals from racial and ethnic groups often involves improving the environments in which they live, including the economic climate within communities. Warren (1978) defines five basic functions of communities, one of which is production-distribution-consumption. This refers to a community's ability to participate in the process for goods and services in a manner that is desirable for its inhabitants. Health care organizations seeking to engage communities should incorporate the concept of reciprocity, and should know to what extent they themselves contribute to the economic viability of the community (e.g. purchase of goods and services from local merchants and hiring members of the community) (Mason, J., 1996). The literature cites practices that support reciprocity as being effective, and recognizes the need for economic benefits and exchange of resources as a foundation for successful community engagement.

■ *Funders Require Community Participation*

There is a growing emphasis on community and consumer participation among grant makers and other entities that fund health, mental health, social service and related research programs. These funders also stress the importance of using cultural and linguistic competence to engage communities and attain their meaningful participation. Many federal and state government agencies require programs to involve communities and consumers in order to receive grant funding. Within the federal government, the Health Resources and Services Administration; the Agency for Healthcare Research and Quality; the National Institutes of Health; the National Institute on Disability, Rehabilitation and Research; the Administration on Children and Families; the Centers for Disease Control and Prevention; and the Substance Abuse and Mental Health Administration all have specific program guidance and mandates for community participation. The Robert Wood Johnson Foundation, John D. and Catherine T. MacArthur Foundation, and Annie E. Casey Foundation also require that grant recipients demonstrate active community participation in planning and implementing the community projects funded by these foundations.

Summary

In summary, the complex and diverse nature of communities mandates approaches to community engagement that are culturally and linguistically competent. To successfully engage communities, health care organizations must understand:

- their own organizational culture, and the cultures of their personnel;
- the diverse cultures represented within the communities they serve;
- the social, political and economic climates of communities within a cultural context; and
- the inherent ability of communities to recognize their own problems, including the health of its members, and intervene appropriately on their own behalf.

Most importantly, health care organizations must demonstrate the capacity to effectively use this knowledge to develop and administer policy, structures, procedures and practices to meet the needs of culturally and linguistically diverse populations.

A major principle of cultural competence involves extending the concept of self-determination beyond the individual to the community (Cross et al., 1989). This guiding principle is particularly relevant to community engagement. The National Center for Cultural Competence embraces a conceptual framework and model for achieving cultural competence based on the Cross et al. definition. Cultural competence requires that organizations:

- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.
- incorporate the above in all aspects of policy making, administration, practice/service delivery and systematically involve consumers/families.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum.

Community Engagement: Policy Implications for Primary Health Care Organizations

Health care organizations should give careful consideration to the values and principles that govern their participation in community engagement. This checklist is designed to guide them in developing and administering policy that supports cultural and linguistic competence in community engagement.

Checklist to Facilitate Cultural Competence in Community Engagement

Does the health care organization have:

- ☐ a mission that values communities as essential allies in achieving its overall goals?
- ☐ a policy and structures that delineate community and consumer participation in planning, implementing and evaluating the delivery of services and supports?
- ☐ a policy that facilitates employment and the exchange of goods and services from local communities?
- ☐ a policy and structures that provide a mechanism for the provision of fiscal resources and in-kind contributions to community partners, agencies or organizations?
- ☐ position descriptions and personnel performance measures that include areas of knowledge and skill sets related to community engagement?
- ☐ a policy, structures and resources for in-service training, continuing education and professional development that increase capacity for collaboration and partnerships within culturally and linguistically diverse communities?
- ☐ a policy that supports the use of diverse communication modalities and technologies for sharing information with communities?
- ☐ a policy and structures to periodically review current and emergent demographic trends to:
 - determine whether community partners are representative of the diverse population in the geographic or service area?
 - identify new collaborators and potential opportunities for community engagement?
- ☐ a policy, structures and resources to support community engagement in languages other than English?

NATIONAL CENTER FOR CULTURAL COMPETENCE • 3307 M STREET, NW, SUITE 401, WASHINGTON, DC 20007-3935
VOICE: 800-788-2066 OR 202-687-5387 • FAX: 202-687-8899 • E-MAIL: CULTURAL@GEORGETOWN.EDU

References Used to Prepare This Policy Brief

- Barber, K., Shaw, R., Folts, M., Taylor, D., Ryan, A., Hughes, M., Scott, V., & Abbott, R. (1998). Differences between African American and Caucasian men participating in a community-based prostate cancer screening program. *Journal of Community Health*, Vol. 23.
- Buluran, N. (1999). The Campaign for 100% access and zero health disparities. *Urban Update*, 1(1), pp. 22-24.
- Campbell, P., U.S. Census Bureau (1996). *Population projections: States, 1995–2025*, published May 1997, <http://www.census.gov/population/www/projections/stproj.html>
- Centers for Disease Control & Prevention (1997). Principles of community engagement. Retrieved April 23, 2001 from the World Wide Web: www.cdc.gov/phppo.
- Covey, S. (1996). Three roles of the leader in the new paradigm. *The leader of the future: New visions, strategies and practices for the next era*. In Hesselbein, F., Goldsmith, M., & Beckhard, R. (Ed.) San Francisco: Jossey-Bass.
- Cross, T., Bazron, B., Dennis, K., and Isaacs, M. (1989). *Towards a culturally competent system of care volume I*. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.
- Davis, K. Scott-Collins, K. & Hill, A. (1999). *Policy brief—Community health centers in a changing U.S. health care system*. The Commonwealth Fund. Retrieved from the World Wide Web April 23, 2001 at http://www.cmf.org/programs/minority/davis_ushealthcenters_300.asp
- Goode, T. & Harrison, S. (2000). *Policy brief 3: Cultural competence in primary health care: Partnerships for a research agenda*. Washington, D.C.: Georgetown University Child Development Center.
- Kouzes, J. M. & Posner, B.Z. (1990). *The leadership challenge*. San Francisco: Jossey-Bass.
- Lipman-Blumen, J. (1996). *The Connecting edge: Leading in an independent world*. San Francisco: Jossey-Bass.
- Mahan, C. (1997). Surrendering control to the locals. *Journal of Public Health Management and Practice*, Vol. 3(1).
- Mason, J. (1996). *Cultural competence self-assessment questionnaire*. Portland, OR: JLM & Associates.
- Melaville, A. & Blank, M. (1991). *What it takes: Structuring interagency partnerships to connect children and families with comprehensive services*. Washington, D.C.: Education and Human Services Consortium.
- Miriam Webster's Collegiate Dictionary- 10th Edition (1994). Springfield, MA: Miriam-Webster, Inc.
- Muskegon Community Health Project. Retrieved April 23, 2001 from the World Wide Web: <http://www.mchp.org>.
- National Center for Cultural Competence (2001). *Sharing a legacy of caring—Partnerships between health care and faith-based organizations*. Washington, D.C.: Georgetown University Child Development Center.
- Roberts, N. & Magrab, P. (1999). The Meaning of community. *Where children live: Solutions for serving children and their families*. Stamford, CT: Ablex Publishing.
- Warren, R. L. (1978). *The community in america (3rd ed)*. Chicago: Rand McNally.
- Williams, G., Abbott, R. & Taylor, D. (1997). Using focus group methodology to develop breast cancer screening programs that recruit African women. *Journal of Community Health*, Vol. 22.
- Williams, J. & Taylor, T. (1994). Community services and supports for people with developmental disabilities, in Gardner, H. G. & Orellove, F. P. (Ed.) *Teamwork in human services*. Boston: Butterworth-Heinemann.
- U.S. Census Bureau, retrieved April 23, 2001 from the World Wide Web: <http://www.census.gov>.
- U.S. Department of Health & Human Services. (2000). *Healthy people 2010: Understanding and improving health*. (Conference Edition, In Two Volumes). Washington, DC: Author.

For More Information...

Bureau of Primary Health Care Community Engagement Initiatives

Communities in Action
<http://bphc.hrsa.gov/CCA>

Faith Partnership Initiative
<http://bphc.hrsa.gov/faith>

Multnomah County Health Department
Lillian Shirley, Director
1120 SW 5th, 14th Floor
Portland, Oregon 97204
Phone: (503) 988-3674
Fax: (503) 988-3676
<http://www.multnomah.lib.or.us/health/index.html>

Sunset Park Family Health Center
Dinah Surh, Administrator
Sunset Park Family Health Network
150 55th Street, Sector #14
Brooklyn, NY 11220
Work Phone: (718) 630-7215
Fax: (718) 630-6828
E-Mail: dsurh@lmcmc.com

Other Community Engagement Initiatives

Friendly ACCESS
The Lawton & Rhea Chiles Center for Healthy Mothers and Babies
University of South Florida
College of Public Health
MDC 56
13201 Bruce B. Downs Blvd.
Tampa, FL 33612-3806
E-mail: friendlyaccs@childescenter.org

Haddington Community Health Project Collaborative

For further information on partnership activities, contact:
Rickie Brawer
Regional Director, Community Services
Main Line Health
100 Lancaster Avenue
Medical Science Building
Wynnewood, PA 19096-3498
Phone: (610) 645.8555
Fax: (610) 526.8099

The Muskegon Community Health Project
<http://www.mchp.org>

Communities Can!

Georgetown University Child Development Center
3307 M Street, N.W., Suite 401
Washington, DC 20007-3935
Phone: (202) 687-5095
E-mail: communities@georgetown.edu

National Heart, Lung, and Blood Institute
Salud para su Corazon (Health for your Heart)
<http://www.nhlbi.nih.gov>
E-mail: NHLBInfo@rover.nhlbi.nih.gov

Centers for Disease Control and Prevention HIV Prevention

<http://www.cdc.gov>
1600 Clifton Rd.
Atlanta, GA 30333
Phone: (800) 311-3435
Phone: (404) 639-3311

About the Authors of this Brief:

Tawara D. Goode, M.A.

*Director of the National Center for Cultural Competence
Georgetown University Child Development Center*

NCCC Faculty and Staff Who Contributed to this Brief:

Suganya Sockalingam, Associate Director

Marisa Brown, Director, BPHC Project

Clare Dunn, Research Associate

Editor: Lisa Lopez

Suggested Citation:

Goode, T. (2001). Policy brief 4: Engaging communities to realize the vision of one hundred percent access and zero health disparities: a culturally competent approach. Washington, D.C.: National Center for Cultural Competence, Georgetown University Child Development Center.

About the



The mission of the National Center for Cultural Competence (NCCC) is to increase the capacity of health care and mental health programs to design, implement and evaluate culturally and linguistically competent service delivery systems. The NCCC conducts an array of activities to fulfill its mission including: (1) training, technical assistance and consultation; (2) networking, linkages and information exchange; and (3) knowledge and product development and dissemination. Major emphasis is placed on policy development, assistance in conducting cultural competence organizational self-assessments, and strategic approaches to the systematic incorporation of culturally competent values, policy, structures and practices within organizations.

The NCCC is a component of the Georgetown University Child Development Center and is housed within the Department of Pediatrics of the Georgetown University Medical Center. The BPHC funds one project of the NCCC. The NCCC operates under the auspices of Cooperative Agreement #U93-MC-00145-06 and is supported in part from the Maternal and Child Health program (Title V, Social Security Act), HRSA, DHHS.

The NCCC is a collaborative project between the Georgetown University Child Development Center and the following Federal government agencies:

Health Resources and Services Administration

Maternal and Child Health Bureau (MCHB)

- Division of Services for Children With Special Health Needs
- Sudden Infant Death Syndrome and Other Infant Death Program
- Division of Research, Training and Education (DRTE)
- Healthy Tomorrows Partnership for Children Program/DRTE

Office of Minority Health

- HRSA Cultural Competence Committee

Bureau of Primary Health Care (BPHC)

- Office of Minority & Women's Health
- National Health Service Corps (NHSC)
- Division of Scholarship and Loan Repayment/NHSC
- Office of Pharmacy Affairs

Other target BPHC programs include Community Health Centers, Migrant Health Centers, Health Care for Homeless grantees, Healthy Schools, Healthy Communities grantees, Health Services for Residents of Public Housing, Primary Care Associations and Offices.

The NCCC also has a partnership with the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Child, Adolescent and Family Branch through another Cooperative Agreement.

FOR ADDITIONAL INFORMATION CONTACT:

National Center for Cultural Competence
Georgetown University Child Development Center
3307 M St., NW, Suite 401 • Washington, DC 20007-3935
Voice: 800-788-2066 or 202-687-5387
TTY: 202-687-5503 • Fax: 202-687-8899
E-mail: cultural@georgetown.edu
URL: <http://gucdc.georgetown.edu/nccc>

Notice of Nondiscrimination

In accordance with the requirements of Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, and Section 504 of the Rehabilitation Act of 1973, and implementing regulations promulgated under each of these federal statutes, Georgetown University does not discriminate in its programs, activities, or employment practices on the basis of the race, color, national origin, sex, age or disability. The University's compliance program under these statutes and regulations is supervised by Rosemary Kilkenney, Special Assistant to the President for Affirmative Action Programs. Her office is located in Room G-10, Darnall Hall, and her telephone number is (202) 687-4798.

Permission is granted to reproduce this document for distribution. The only requirement is that proper credit be given to the National Center for Cultural Competence.



National
Center
for
Cultural
Competence

Policy Brief 2

GEORGETOWN UNIVERSITY CENTER FOR CHILD AND HUMAN DEVELOPMENT ■ UNIVERSITY CENTER FOR EXCELLENCE IN DEVELOPMENTAL DISABILITIES

Linguistic Competence in Primary Health Care Delivery Systems: Implications for Policy Makers

Nationally, linguistic diversity creates complex challenges for health care delivery systems. During the last decade the number of people in need of health care services who have limited English proficiency has risen dramatically. (The term limited English proficiency as used in this brief includes those individuals who do not speak English). Accurate and honest communication between health care providers and patients is essential for the effective delivery of quality health care services. Significant barriers exist in the delivery of linguistically competent health care services. These include but are not limited to the following:

- Although Title VI of the Civil Rights Act of 1964 prohibits discrimination against persons with limited English proficiency, there are statutes in many states that have English only requirements. The use of state funds to provide linguistic access services is strictly prohibited by these states. There is a perception that even Federal funds can not be used for the provision of linguistic access services within English only states. This continues to be litigated at the state and Federal levels.
- Standards for linguistic access have not been issued at the Federal level. In the absence of such Federal standards, there have been varying degrees of responsiveness among states. Very few states have developed standards for linguistic access. Those which have placed emphasis on Managed Care Organizations, provider contracting, and specific health and mental health services in defined settings.
- Health care providers are not typically trained in academic and continuing education settings to work with interpreters in providing services to people with limited English proficiency.
- There are shortages in qualified personnel to provide medical translation and interpretation services especially in rural areas.
- Inadequate resources have been allocated for the provision of translation and interpretation services at the state and local levels.
- Segments of the immigrant and refugee population are unlikely to advocate for translation and interpretation services due to linguistic and cultural barriers, which include the perception of adverse political repercussions.

These barriers highlight the need for primary health care organizations to develop and execute policies, structures, practices and procedures to support the delivery of linguistically competent health care services.

Rationale for Linguistic Competence in Primary Health Care Delivery Systems

■ *Changing Demographics*

According to 1990 Census data, 32 million people in the United States, or 13.8% of the population, speak a language other than English at home. Most current Census data indicate that there are over 300 languages spoken in the United States. This trend is expected to continue.

■ *It's the Law!!*

Title VI—Prohibition Against National Origin Discrimination—has specific provisions addressing persons with limited English proficiency. This Federal law and related guidance mandate the development of policies and procedures that address the language assistance needs for effective communication between health and social service providers and persons with limited English proficiency (See text box on page 3). This statute

mandates language assistance when language barriers cause persons with limited English proficiency to be excluded from or denied equal access to programs funded by the U.S. Department of Health and Human Services. Some states have enacted legislation that require health care organizations to provide linguistic access based on predetermined population thresholds within a defined geographic area.

■ *Improved Access and Cost of Care*

Persons with limited English proficiency are not likely to seek health care services unless the providers meet their linguistic needs. Delays in seeking health care often result in the need for costly services to treat advanced stages of diseases. This has serious ramifications for both the health care delivery system and the individual. Invasive diagnostic and treatment procedures, specialty care, lengthy hospitalization and long-term care are costly. Delayed access to health care may result in lost wages, decreased productivity and an increased risk for chronic illness, disability, undue suffering and possibly death.

Studies have documented evaluation approaches and the cost benefits of providing interpretation services. Health maintenance organizations (HMOs) are beginning to recognize the benefit in providing interpreter services. In one midwestern state, three of the largest Medicaid HMOs consider interpretation services equivalent to social services and recognize that failure to provide these services transforms simple medical problems into complicated and expensive treatment and management issues. Chang, et al., 1998.

■ *Meeting Accreditation Standards*

Accrediting agencies that review and certify hospitals and other health care facilities play a pivotal role in setting standards. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which accredits hospitals and other health care institutions such as home health care and psychiatric facilities, and the National Committee for Quality Assurance (NCQA), which accredits managed care organizations and behavioral health managed care organizations (MCOs), have adopted standards that require language access in health care.

JCAHO standards require health care organizations to “have a way of providing for effective communication for each patient served”. JCAHO standards expect that patient and family education take into account culture and language. The NCQA requires that MCO enrollees be provided with written materials that they can understand. This standard, however, only applies when 10% or more of the MCO membership is non-English speaking.

■ *Decrease the likelihood of liability and malpractice claims*

Failure to provide interpretation and translation services may result in liability under tort principles in several ways. For example, providers may discover that they are liable for damages as a result of treatment in the absence of informed consent. Also in some states the failure to convey treatment instructions accurately may raise a presumption of negligence on the part of the provider.

The ability to communicate well with patients has been shown to reduce the likelihood of malpractice claims. A study appearing in the Journal of the American Medical Association indicates that the patients of physicians who are frequently sued had the most complaints about communication. Physicians who had never been sued were likely to be described as concerned, accessible and willing to communicate. The use of qualified medical interpretation and translation services enhances patient-provider communication, thereby decreasing the risk of malpractice. Other studies support this fact (Physicians Risk Management Update, 1995; American Medical News, 1996; Virshup, et al., 1996; Meryn, 1998; American Family Physician, 1997; Hospital Topics, 1997; JAMA, The Journal of the American Medical Association, 1997).

■ *Increasing the market share*

In today’s competitive health care industry, strategies to increase the recruitment and retention of satisfied health care consumers are essential to the survival of primary health care organizations. Providing interpretation and translation services is a key strategy given the current population profiles and projected trends.

IT'S THE LAW!

Selected Federal laws and regulations that mandate linguistic competence:

■ TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

“No person in the United States shall, on ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” Guidance issued by the Office of Civil Rights further clarifies Title VI as it relates to persons with limited English proficiency. Specifically, providers should establish and implement policies and procedures to fulfill their Title VI equal opportunity responsibilities including reasonable steps to provide services and information in appropriate languages other than English to ensure that persons with limited English proficiency are effectively informed and can effectively participate in any benefit. Nearly every health care provider is bound by Title VI, because Federal funding of health care is almost universal.

■ THE HILL-BURTON ACT

Enacted by Congress in 1946, the Hill-Burton Act encouraged the construction and modernization of public and nonprofit community hospitals and health centers. In return for receiving these funds, recipients agreed to comply with a “community service obligation”, one of which is a general principle of non-discrimination in the delivery of services. The Office of Civil Rights has consistently interpreted this as an obligation to provide language assistance to those in need.

■ MEDICAID

Medicaid, a Federal-state cooperative program of medical assistance, provides health insurance to adolescents, children and families who are poor, and people with disabilities and those who are indigent and elderly. Medicaid regulations require Medicaid providers and participating agencies, including long-term care facilities, to render culturally and linguistically appropriate services. The Health Care Financing Administration, the Federal agency that oversees Medicaid, requires that states communicate both orally and in writing “in a language understood by the beneficiary” and provide interpretation services at Medicaid hearings.

■ MEDICARE

Medicare is a Federal program that provides insurance to people 65 years of age or older, with certain disabilities who are under 65 years of age, and of any age with permanent kidney failure. Medicare addresses linguistic access in its reimbursement and outreach education policies. Medicare “providers are encouraged to make bilingual services available to patients wherever the services are necessary to adequately serve a multilingual population”. Medicare reimburses hospitals for the cost of the provision of bilingual services to patients.

■ EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

This Act requires hospitals with emergency departments that participate in the Medicare program to treat all patients (including women in labor) in an emergency without regard to their ability to pay. The EMTALA Act was passed to reduce the practice of “dumping” patients who lacked the financial ability to incur hospital costs. EMTALA stipulates a hospital’s responsibilities to the patient which include the diagnosis, treatment, informed consent, and notification of condition and intent to transfer to another facility. Hospitals that fail to provide language assistance to persons of limited English proficiency are potentially liable to federal authorities for civil penalties as well as relief to the extent deemed appropriate by a court.

Linguistic Competence: Policy Making Implication for Primary Health Care Organizations and Programs

Health care organizations have been slow to develop and implement policies and structures to guide the provision of interpretation and translation services. In the absence of policies, structures and fiscal resources, the burden of such services remain at the practitioner and consumer level. The following checklist is designed to assist primary health care organizations in developing policies, structures, practices and procedures that support linguistic competence.

Checklist to Facilitate the Development of Linguistic Competence within Primary Health Care Organizations

Does the primary health care organization or program have:

- ☐ a mission statement that articulates its principles, rationale and values for providing linguistically and culturally competent health care services?
- ☐ policies and procedures that support staff recruitment, hiring and retention to achieve the goal of a diverse and linguistically competent staff?
- ☐ position description and personnel/performance measures that include skill sets related to linguistic competence?
- ☐ policies and resources to support ongoing professional development and inservice training (at all levels) related to linguistic competence?
- ☐ policies, procedures and fiscal planning to ensure the provision of translation and interpretation services?
- ☐ policies and procedures regarding the translation of patient consent forms, educational materials and other information in formats that meet the literacy needs of patients?
- ☐ policies and procedures to evaluate the quality and appropriateness of interpretation and translation services?
- ☐ policies and procedures to periodically evaluate consumer and personnel satisfaction with interpretation and translation services that are provided?
- ☐ policies and resources that support community outreach initiatives to persons with limited English proficiency?
- ☐ policies and procedures to periodically review the current and emergent demographic trends for the geographic area served in order to determine interpretation and translation services needs?

NATIONAL CENTER FOR CULTURAL COMPETENCE • 3307 M STREET, NW, SUITE 401, WASHINGTON, DC 20007-3935
VOICE: 800-788-2066 OR 202-687-5387 • FAX: 202-687-8899 • E-MAIL: CULTURAL@GEORGETOWN.EDU

DEFINITIONS

The terms interpretation and translation are often used interchangeably. The NCCC makes a distinction between the two terms and has provided the following definitions.

Translation typically refers to the written conversion of written materials from one language to another.

Interpretation is the oral restating in one language of what has been said in another language.

References Used to Prepare This Policy Brief

Anderson, J. (1999). The State of "English Only". *The Washington Post*. June 6, 1999.

Balon, R.; Frank, G.; and Levinson, W. (1997). Malpractice claims and physician's communication patterns. *The Journal of the American Medical Association*. 277 (21):1681.

Branigin, W. (1999). The spread of Spanish greeted by some unwelcome signs: Businesses facing language restrictions. *The Washington Post*. June 6, 1999.

Chang, P. and Puebla Fortier, J. (1998). Language barriers to health care: An overview. *Journal of Health Care for the Poor and Underserved*. (9). S5-S20.

Clements, B. (1996). Talk is cheaper than three extra office visits. Good communication can save time and money in managed care. *American Medical News*. January, 39. (4):17.

Darr, K. (1997). Communication: the key to reducing malpractice claims. *Hospital Topics*. Spring, 75 (2):4.

Fein, E. (1997). Language barriers are hindering health care. *The New York Times*. November 23, 1997.

Hornberger, J. (1995). Evaluating the costs of bridging language barriers to health care. *Journal of Health Care for the Poor and Underserved*. (9). S40-S62.

Huffman, G. (1997). Physician communication and risk of malpractice claims. *American Family Physician*. 56. (1): 239.

Levinson, W.; Roter, D.; Mullooly, J.; Dull, T.; Frankel, R. (1997). Physician-patient communication: the relationship with malpractice claims among primary care physicians and surgeons. *The Journal of the American Medical Association*. 277 (7):553.

Meryn, S. (1998). Improving doctor-patient communication: not an option, but a necessity. *British Medical Journal*. 316. (7149):1922.

Perkins, J., Simon, H. Cheng, F., Olson, K. and Vera, Y. (1998). Ensuring linguistic access in health care settings: Legal rights and responsibilities. Los Angeles, CA: The Henry J. Kaiser Family Foundation.

Riddick, S. (1998). Improved access for limited English-speaking consumers: A review of strategies in health care settings. *Journal of Health Care for the Poor and Underserved*. 9. S40-S62.

Virshup, B., Oppenberg, A., Coleman, M. (1999). Strategic risk management: Reducing malpractice claims through more effective patient-doctor communication. *American Journal of Medical Quality*. 14. (4):153-159.

_____. (1995). Poor communication with patients can get you sued. *Physicians Risk Management Update*. VI (1):1.

The NCCC acknowledges the contributions of Elena Cohen in assisting with the literature review for this brief.

For More Information...

For more information on the topics covered in this policy brief, please see the listing of resources below.

TOPIC AREA Statistics and Demographic Data

Statistics about immigration patterns available at <http://www.immigration.gov/graphics/index.htm> (April 24, 2003)

National, state, and county statistic and demographic data by age, racial, ethnic and linguistic subgroups is available at

General Information	www.census.gov
Population Estimates	http://eire.census.gov/popest/estimates.php (April 24, 2003)
Population Projections	www.census.gov/population/www/projections/popproj.html (April 24, 2003)

Continued

TOPIC AREA Providing Linguistically Competent Health Care Services to People of Diverse Racial/Ethnic Backgrounds

The websites of the following organizations provide an array of information and resources on providing culturally and linguistically competent health services and medical interpreting.

Diversity RX: www.diversityrx.org (April 24, 2003)

National Multicultural Institute: www.nmci.org (April 24, 2003)

Cross Cultural Health Care Program: www.xculture.org (April 24, 2003)

**Center for Immigrant Health,
New York University School of Medicine:** www.med.nyu.edu/cih/ (April 24, 2003)

Office for Civil Rights Policy Guidance: www.hhs.gov/ocr/lep (April 24, 2003)

For additional information on medical interpretation and translation services contact:

The National Council on Interpretation in Health Care
Cross Cultural Health Care Program at PacMed Clinics
1200 12th Avenue S. Seattle, WA 98144
www.xculture.org

Acknowledgements

Special thanks to Carole Brown, Office for Civil Rights, Department of Health and Human Services, and Wendy Pailen, Office of General Counsel, Civil Rights Division, Department of Health and Human Services, for their contributions to the revisions to this policy brief.

About the



The mission of the National Center for Cultural Competence (NCCC) is to increase the capacity of health care and mental health programs to design, implement and evaluate culturally and linguistically competent service delivery systems. The NCCC conducts an array of activities to fulfill its mission including: (1) training, technical assistance and consultation; (2) networking, linkages and information exchange; and (3) knowledge and product development and dissemination. Major emphasis is placed on policy development, assistance in conducting cultural competence organizational self-assessments, and strategic approaches to the systematic incorporation of culturally competent values, policy, structures and practices within organizations.

The NCCC is a component of the Georgetown University Center for Child and Human Development (GUCCHD) and is housed within the Department of Pediatrics of the Georgetown University Medical Center. It is funded and operates under the auspices of Cooperative Agreement #U93-MC-00145-09 and is supported in part from the Maternal and Child Health program (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services (DHHS). NCCC shares partnerships with two Federal departments, two Federal administrations, one Federal agency and nine of their respective bureaus, divisions, branches, offices, institutes, and programs. Additionally the NCCC conducts a collaborative project under the auspices of another Cooperative Agreement with the GUCCHD and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, DHHS.

FOR ADDITIONAL INFORMATION CONTACT:

National Center for Cultural Competence
Georgetown University Center for Child and Human Development
3307 M Street, NW, Suite 401 • Washington, DC 20007-3935
Voice: 800-788-2066 or 202-687-5387 • TTY: 202-687-5503 • Fax: 202-687-8899
E-mail: cultural@georgetown.edu • URL: <http://gucdc.georgetown.edu/nccc>

Notice of Nondiscrimination

In accordance with the requirements of Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, and Section 504 of the Rehabilitation Act of 1973, and implementing regulations promulgated under each of these federal statutes, Georgetown University does not discriminate in its programs, activities, or employment practices on the basis of race, color, national origin, sex, age, or disability. The University's compliance program under these statutes and regulations is supervised by Rosemary Kilkenny, Special Assistant to the President for Affirmative Action Programs. Her office is located in Room G-10, Darnall Hall, and her telephone number is (202) 687-4798.



National
Center
for
Cultural
Competence

Policy Brief 1

GEORGETOWN UNIVERSITY CENTER FOR CHILD AND HUMAN DEVELOPMENT ■ UNIVERSITY CENTER FOR EXCELLENCE IN DEVELOPMENTAL DISABILITIES

Rationale for Cultural Competence in Primary Care

The National Center for Cultural Competence views mental health as an integral and inseparable aspect of primary care. For the purposes of this brief, the term primary care refers to both health care and mental health services, and to the providers of such services.

Nationally, organizations and programs that provide primary care are struggling to respond effectively to the needs of individuals and families from racially, ethnically, culturally and linguistically diverse groups. The incorporation of culturally competent approaches within primary care systems remains a great challenge for many states and communities. Numerous reasons justify the need for cultural competence at the patient-provider level. These include but are not limited to the following:

- the perception of illness and disease and their causes varies by culture;
- diverse belief systems exist related to health, mental health, healing and well-being;
- culture influences help-seeking behaviors and attitudes toward primary care providers;
- individual preferences affect traditional and other approaches to primary care;
- patients must overcome personal experiences of biases within primary care systems; and
- primary care providers from culturally and linguistically diverse groups are under-represented in current service delivery systems.

These patient-provider issues substantiate the need for primary care organizations, delivering both health and mental health care services, to develop values, policies, structures and practices that are culturally and linguistically competent. The rationale to incorporate cultural competence into organizational policy are numerous. The Center has identified seven salient reasons for review in this policy brief.

Why is there a compelling need for cultural competence?

■ To respond to current and projected demographic changes in the United States.

The make-up of the American population continues to change as a result of immigration patterns and significant increases among racially, ethnically, culturally and linguistically diverse populations already residing in the United States. Primary care organizations and Federal, state and local governments must implement systemic change in order to meet the health and mental health needs of this diverse population. 2000 Census data show that over 47 million persons speak a language other than English at home, up nearly 48% since 1990. Although the majority are able to speak English, over 21 million speak English less than “very well”, up 52% from 14 million in 1990 (Census, 2000). Since 1990, the foreign-born population has grown by 64% to 32.5 million persons, accounting for 11.5% of the U.S. population (Schmidley, 2003). The trend is expected to continue. By the year 2030, the Census Bureau predicts that 60% of the U.S. population will self-identify as White, non-Hispanic, and 40% will self-identify as members of other diverse racial and ethnic groups.

■ To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds.

Nowhere are the divisions of race, ethnicity and culture more sharply drawn than in the health of the people in the United States. Despite recent progress in overall national health, there are continuing disparities in the incidence of illness and death among African Americans, Latino/Hispanic Americans, Native Americans, Asian Americans, Alaskan Natives and Pacific Islanders as compared with the U.S. population as a whole. The U.S. Department of Health and Human Services (DHHS), through its 2010 Objectives, established goals for the elimination of racial and ethnic disparities in health. Six major areas of health status have been targeted for elimination including cancer, cardiovascular disease, infant mortality, diabetes, HIV/AIDS and child and adult immunizations. Regrettably, since this Brief was originally published in 1999, there has been little change in these indicators of illness and death.

- **Cancer.** Research shows, in general, that people of diverse racial and ethnic groups are less likely to get regular medical checkups, receive immunizations, and be routinely tested for cancer, when compared with the majority U.S. population.
 - African-Americans have the highest rates of cancer of any racial/ethnic group in the U.S.
 - Cancer deaths are disproportionately high among Latino/Hispanic Americans.
 - Vietnamese women are five times more likely and Mexican and Puerto Rican women 2 to 3 times more likely to have cervical cancer than White women. (Intercultural Cancer Council, 2001).
- **Cardiovascular disease.** Disparities exist both in the prevalence of risk factors for cardiovascular disease (coronary heart disease and stroke) and the way in which care is delivered.
 - African Americans have by far the highest death rate for stroke and coronary heart disease, and the prevalence of high blood pressure in African Americans is among the highest in the world (American Heart Association, 2002).
 - Stroke is the only leading cause of death for which mortality is higher for Asian-American men.
 - Obesity continues to be higher for African American and Mexican-American women compared to non-Hispanic White women. (CDC, 2002).
 - Schulman et al (1999), in a study published in the New England Journal of Medicine, found that physicians were significantly less likely to refer African-American women for catheterization than White men.
 - In a study by Nelson et al. (2002), African Americans and Mexican Americans were less likely to report serum cholesterol screening than Whites. African Americans and Mexican Americans were also less likely than Whites to take cholesterol-lowering agents when identified as having high cholesterol requiring medication.
- **Infant mortality.** Current studies document that despite recent advances, African American and Native American babies still die at a much higher rate than the rate for White American babies (Health, United States, 2002).
 - Sudden Infant Death Syndrome (SIDS) mortality rates for Native Americans are almost 3 times higher and for African-Americans more than 2 times higher than for Whites (National Vital Statistics Systems, cited by DHHS).
 - While the overall infant mortality rate has declined, the gap between Black and White infant mortality rates has widened.
- **Diabetes.** Diabetes has been recently described as reaching epidemic proportions in the United States. Studies indicate that diabetes is the sixth leading cause of death in the United States (National Vital Statistics Report, 2002). Approximately 17 million people in the United States have diabetes (DHHS, 2002). Disparities in the treatment of diabetes are also well documented in the literature.
 - American Indians and Alaska natives are 2.6 times as likely and Mexican-Americans and African-Americans are 2 times as likely as non-Hispanic Whites to have diagnosed diabetes (CDC, 2002).
 - Native Americans, Hispanic/Latinos and African Americans have higher rates of diabetes-related complications such as kidney disease, blindness, and amputation as compared to the White population.
 - African-Americans are more likely to develop end stage renal disorder due to diabetes but Whites receive 92% of all transplants (Isaacs et al, 2000). Even among patients who expressed a “very certain” desire for kidney transplantation, African Americans are significantly less likely than Whites to be referred by medical personnel for transplantation (Ayanian, 1999).
- **HIV/AIDS.** Recent data from prevalence surveys and from HIV/AIDS case surveillance continue to reflect the disproportionate impact of the epidemic on racially and ethnically diverse groups, especially women, youth and children.
 - Of AIDS cases reported to CDC through 2001, African Americans and Hispanics accounted for 78% of the cases among women and 82% of the cases among children (CDC, 2002).
- **Child and Adult Immunizations.** Immunization levels for school age children and elder adults of diverse racial and ethnic backgrounds continue to lag when compared to the overall vaccination rates of the general U.S. population.
 - Even with the same insurance, Hispanic elderly were less likely to receive flu and pneumonia immunizations (Mark & Paramore, 1996 as cited in Mayberry et al, 1999).
 - Even with the availability of vaccines, the rate of Hepatitis B in adults and high-risk groups is 3 to 4 times higher for African Americans and Asians than for Whites; and twice as high for Native Americans as Whites (CDC Wonder, retrieved 7/17/01).

The evidence clearly suggests a complex array of factors contribute to racial and ethnic disparities in health. Many of these factors are well documented, some are interrelated, while others are not well understood and

require more research. The groundbreaking report by the Institute of Medicine (IOM), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002), verifies this premise with compelling evidence. Selected findings of the IOM state that:

- racial and ethnic disparities in healthcare occur within the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life.
- many factors—including health systems, healthcare providers, patients and utilization managers—may contribute to racial and ethnic disparities in healthcare.
- bias, stereotyping, prejudice and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare.

■ **To eliminate disparities in the mental health status of people of diverse racial, ethnic and cultural groups.**

Racial and ethnic disparities in mental health are as prevalent as the previously described areas of health disparity. The literature documents the complicated correlation of risk factors, disease incidence, and social, biological and behavioral factors that contribute to these disparities.

- The first ever Surgeon General's report on mental health issued in 1999 emphasized the importance of culture for both patients and providers. "The cultures that patients come from shape their mental health and affect the types of mental health services they use. Likewise, the cultures of the clinician and the service system affect diagnosis, treatment, and the organization and financing of services." (Executive Summary). This report documents pervasive disparities in mental health care and that racially and ethnically diverse groups:
 - are less likely to receive needed mental health services and more likely to receive poorer quality of care.
 - are over represented among the vulnerable populations who have higher rates of mental disorders and more barriers to care.
 - face a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health.
- Moreover, there is a clear correlation between chronic physical illness and mental illness. According to the Supplement to the Surgeon General's Report (2001), chronic physical illness is recognized as a risk factor for mental illness when risk is considered for individuals. A single risk factor increases the probability of mental illness and must also be considered within the presence of other individual, family and community risk factors along with the presence of protective factors such as spirituality, supportive family relationships and availability of health and social services within the community.
- The IOM published a report entitled *Health and Behavior: The Interplay of Biological, Behavioral, and Societal Influences* (2001) which defines health broadly, including the positive concept of well-being. According to the IOM, almost half of all the deaths in the U.S. are linked to behavioral and social factors.

These reports lend credence to the world view of many cultural groups whose belief systems integrate physical, emotional and spiritual well-being, and hold that all three are necessary for their overall health and well-being.

■ **To improve the quality of services and primary care outcomes.**

Despite similarities, fundamental differences among people arise from such cultural factors as nationality, ethnicity, acculturation, language, religion, gender and age, as well as those attributed to family of origin and individual experiences. These differences affect the health beliefs and behaviors of both patients and providers. They also influence the expectations that patients and providers have of each other.

The delivery of high-quality primary care that is accessible, effective and cost-efficient requires providers to have a deeper understanding of the socio-cultural background of patients, their families and the environments in which they live. Recent studies have shown that culturally and linguistically competent primary care increases patient satisfaction, health outcomes, and higher levels of preventive care (Lasater et al, 2001; Lee et al, 2002; Saha et al, 1999).

Critical factors in the provision of culturally competent care include understanding the:

- beliefs, values, traditions and practices of individuals and families within their cultural context;
- culturally-defined strengths and needs related to health and mental health of individuals, families and communities;
- culturally-based belief systems of the etiology of illness and disease and those related to health, healing and well-being; and
- attitudes toward seeking help from primary care providers.

Providers must understand the beliefs that shape a person's approach to health, well-being and illness. Knowledge of customs and healing traditions are indispensable to treatment and interventions. Primary care—health and mental health services—must be received *and* accepted to be successful.

Increasingly, cultural awareness, knowledge and skills are important to personnel responsible for quality assurance programs. In addition, those who design evaluation methodologies for quality improvement must address hard questions about the relevance and efficacy of primary care interventions. Cultural competence will have to be inextricably linked to the definition of specific outcomes and to an ongoing system of accountability that is committed to reducing the current health and mental health disparities among racial and ethnic populations.

■ **To meet legislative, regulatory and accreditation mandates.**

The requirement for care to be delivered in a culturally and linguistically competent manner is increasingly emphasized by legislative, regulatory and accrediting bodies.

■ **Legislative and Regulatory**

As both an enforcer of civil rights law and a major purchaser of health care services, the Federal government has a pivotal role in ensuring culturally competent health care services. Title VI of the Civil Rights Act of 1964 mandates that “no person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” In 2000, the Office of Civil Rights issued a policy guidance for Title VI. Also in 2000, DHHS, Office of Minority Health published the final national standards on culturally and linguistically appropriate services (CLAS) in health care.

The Health Care Fairness Act of 1999 was passed as PL 106-525, the Minority Health and Health Disparities Research and Education Act of 2000, to establish a Center at the National Institutes of Health for the purpose of addressing continuing disparities in the burden of illness and death experienced by diverse racial, ethnic and cultural groups.

■ **Accreditation**

State and Federal agencies rely on private accreditation entities to set standards and monitor compliance. The Joint Commission on the Accreditation of Healthcare Organizations, which accredits hospitals and other health care institutions, the Liaison Committee on Medical Education, the accrediting organization for medical education, and the National Committee for Quality Assurance, which accredits managed care organizations and behavioral health managed care organizations, support standards that require cultural and linguistic competence in health care.

Bureau of Primary Health Care Policy Information Notice 98-23, (8/17/98)

Health centers serve culturally and linguistically diverse communities and many serve multiple cultures within one center. Although race and ethnicity are often thought to be dominant elements of culture, health centers should embrace a broader definition to include language, gender, socio-economic status, housing status and regional differences. Organizational behavior, practices, attitudes and policies across all health center functions must respect and respond to the cultural diversity of communities and clients served. Health centers should develop systems that ensure participation of the diverse cultures in their community, including participation of persons with limited English-speaking ability, in programs offered by the health center. Health centers should also hire culturally and linguistically appropriate staff.

■ To gain a competitive edge in the market place.

A significant proportion of publicly financed primary care services continue to be delegated to the private sector. In the current social and political environment, skyrocketing health care costs, quality and effectiveness of service delivery continue to be of utmost concern. Organizations that embrace the values of cultural competence, and which infuse such practices in the provision of primary care are not only well positioned in the current market place, but also for the future as the diversity of the U.S. population continues to increase. Primary care organizations must be able to support their providers to acquire cultural knowledge, and develop skill sets that will enable them to work effectively with diverse patient populations. Implementing culturally competent service delivery systems can positively impact provider recruitment and retention, patient access to and satisfaction with care, and maintain or increase market share. The literature cites the challenges and opportunities that health care and mental health organizations must undertake to both reach this market and provide services in an effective and culturally competent manner.

- Roberto Suro (2000) states that “For both public and private healthcare providers, a burgeoning new market awaits, replete with disproportionately young, child-bearing, and often upwardly mobile consumers. But gaining access to that market requires a running jump across many cultural divides” (p. 2).
- Racially and ethnically diverse customers spent \$25 billion on pharmaceuticals in 1999. Despite this, Thorne (2001) states that these customers represent “largely untapped markets” and notes that “historically, the industry has been more comfortable with addressing linguistic rather than cultural differences” (p. 3).

■ To decrease the likelihood of liability/malpractice claims.

Lack of awareness about cultural differences, and failure to provide interpretation and translation services, may result in liability under tort principles in several ways. For example, providers may discover that they are liable for damages as a result of treatment in the absence of informed consent. Also, primary care organizations and programs face potential claims that their failure to understand beliefs, practices and behaviors on the part of providers or patients breaches professional standards of care. In some states, failure to follow instructions because they conflict with values and beliefs may raise a presumption of negligence on the part of the provider.

The ability to communicate well with patients has been shown to reduce the likelihood of malpractice claims. A study appearing in the *Journal of the American Medical Association* (1997) indicates that the patients of physicians who are frequently sued had the most complaints about communication. Physicians who had never been sued were likely to be described as concerned, accessible and willing to communicate. When providers treat patients with respect, listen to them, give them information and keep communication lines open, therapeutic relationships are enhanced and risks of malpractice lawsuits can be reduced.

Effective communication between providers and patients may be even more challenging when there are cultural and linguistic barriers. Primary care organizations and programs must address linguistic competence—ensuring for accurate and effective communication in languages other than English and addressing the communication needs of persons with disabilities and those who are not literate or with low literacy. This will require policy, structures, practices, procedures, and dedicated resources to support this capacity (Goode & Jones, 2002).

Rationale for Cultural Competence: Policy Making Implications for Primary Care Organizations and Programs

The NCCC has documented since 1995 that policy is the most underdeveloped area of the many cultural competence efforts within Maternal and Child Health (Title V) programs serving children with special health care needs and their families. This observation extends to other service systems including primary health care, mental health, social services and education. A recent review of the literature reveals that many of the current efforts in health and social services lack the values, policies, planning processes and organizational structures that support culturally competent practices at both the institutional and community levels. Systematic efforts must be implemented by policy makers and planners of services to: (1) effect change within systems and organizations, (2) enhance quality of services and access to primary care, and (3) improve outcomes for racially and ethnically diverse groups. Such sustained efforts can have a profound impact on the goal to eliminate racial and ethnic disparities in both health and mental health care.

The National Center for Cultural Competence embraces a conceptual framework and model for achieving cultural competence based on the Cross et al. definition (1989). Cultural competence requires that organizations:

- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.
- incorporate the above in all aspects of policy making, administration, practice/service delivery and involve systematically consumers/families.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum.

A wealth of literature and other resources has been published and widely disseminated to assist practitioners and direct service providers to deliver culturally competent services. The integration of culturally competent values and principles within the policy realm of primary care service delivery systems is both a challenge and an opportunity.

The following checklist is designed for individuals who have a role in shaping policy at the Federal, state, local and program levels. Policy makers may be board members of community health centers or private agencies, public agency officials, legislators, commissioners, advisory committee members, agency directors and staff of consumer/family organizations. The goal of this checklist is to facilitate policy making that supports culturally and linguistically competent primary care. The questions directly relate to the seven areas of rationale presented in this policy brief.

Checklist to Facilitate the Development of Culturally and Linguistically Competent Primary Care Policies and Structures

Does the primary care system, organization or program have:

- ☐ a mission statement that articulates its principles, rationale and values for culturally and linguistically competent health and mental health care service delivery?
- ☐ policies and procedures that support a practice model which incorporates culture in the delivery of services to culturally and linguistically diverse groups ?
- ☐ structures to assure the meaningful participation of consumers and communities in planning, delivery and evaluation of services?
- ☐ processes to review policy and procedures systematically to assess their relevance for the delivery of culturally competent services?
- ☐ policies and procedures for staff recruitment, hiring and retention that will achieve the goal of a diverse and culturally competent workforce?
- ☐ policies and resources to support ongoing professional development and inservice training (at all levels) for awareness, knowledge and skills in the area of cultural and linguistic competence?
- ☐ policies to assure that new staff are provided with training, technical assistance and other supports necessary to work within culturally and linguistically diverse communities?
- ☐ position descriptions and personnel/performance measures that include skill sets related to cultural and linguistic competence?
- ☐ fiscal support and incentives for the improvement of cultural competence at the board, agency, program and staff levels?
- ☐ policies for and procedures to review periodically the current and emergent demographic trends for the geographic area it serves?
- ☐ methods to identify and acquire knowledge about health beliefs and practices of emergent or new populations in service delivery areas?
- ☐ policies and allocated resources for the provision of translation and interpretation services, and communication in alternative formats?
- ☐ policies and resources that support community outreach initiatives for those with limited English proficiency and/or populations that are not literate or have low literacy skills?
- ☐ requirements that contracting procedures and proposals and/or request for services include culturally and linguistically competent practices?

NATIONAL CENTER FOR CULTURAL COMPETENCE • 3307 M STREET, NW, SUITE 401, WASHINGTON, DC 20007-3935
VOICE: 800-788-2066 OR 202-687-5387 • TTY 202-687-5503 • FAX: 202-687-8899 • E-MAIL: CULTURAL@GEORGETOWN.EDU

References Used to Prepare This Policy Brief

- American Heart Association. (2002). *Cardiovascular Disease Statistics*. Retrieved August, 2002, from www.americanheart.org
- Ayanian, J. Z., Cleary, P. D., Weissman, J. S., & Epstein, A. M. (1999). The effect of patient's preferences on racial differences in access to renal transplantation. *The New England Journal of Medicine*, 341(2), 1661-1669.
- Bureau of Primary Health Care, Health Resources and Services Administration, Department of Health and Human Services. *BPHC policy information notice: 98-23 Date: August 17, 1998*. Retrieved March 27, 2003, from <http://bphc.hrsa.gov/Grants/wordocs/Pin98-23%20HC%20Prog%20Expectations.pdf>
- Centers for Disease Prevention and Control, CDC Wonder. *Data 2010: The healthy people 2010 database, June 2001 edition*. Retrieved July 17, 2001, from www.cdc.gov
- Centers for Disease Prevention and Control, CDC Wonder. *Data 2010: The healthy people 2010 database (2000): Focus area: 01-Access to quality health services*. Retrieved July 17, 2001, from www.cdc.gov
- Centers for Disease Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion. (2002). *National diabetes fact sheet*. Retrieved March 3, 2003, from <http://www.cdc.gov/diabetes/pubs/estimates.htm>
- Centers for Disease Prevention and Control, National Center for Health Statistics. (2002). *Health, United States, 2002*. Retrieved March 3, 2002, from <http://www.cdc.gov/nchs/>
- Centers for Disease Prevention and Control. (2002). *HIV/AIDS among African-Americans: Key facts*. Retrieved March 3, 2003, from www.cdc.gov
- Centers for Disease Prevention and Control. (2002). *HIV/AIDS among Hispanics in the United States*. Retrieved March 27, 2003, from www.cdc.gov/hiv/pubs/facts/hispanic.htm
- Centers for Disease Prevention and Control, National Center for Health Statistics. (2002). *Prevalence of overweight and obesity among adults: United States 1999-2000*. Retrieved March 3, 2003, from <http://www.cdc.gov/nchs/>
- Centers for Disease Prevention and Control, National Center for Health Statistics. (2002). *Prevalence of overweight among children and adolescents: United States 1999-2000*. Retrieved March 3, 2002, from <http://www.cdc.gov/nchs/>
- Centers for Disease Prevention and Control. (1990). Topics in minority health: Health beliefs and compliance with prescribed medication for hypertension among Black women—New Orleans, 1985-86. *Morbidity and Mortality Weekly Report*, 39(40), 701-704.
- Clayton, L. A., & Byrd, W. M. (1993). African-American cancer crisis, part 1: The problem. *Journal of Health Care for the Poor and Underserved*, 4(2), 83-101.
- Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care, vol. 1*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.
- Goode, T., & Jones, W. (2002). *Definition of linguistic competence*. Washington, DC: National Center for Cultural Competence, Georgetown University for Child and Human Development.
- Institute of Medicine. (2001). *Health and behavior: The interplay of biological, behavioral, and societal influences*. Washington, DC: Committee on Health and Behavior: Research, Practice and Policy, Board on Neuroscience and Behavioral Health.
- Intercultural Cancer Council. *Native Hawaiians and Pacific Islanders and cancer*. Retrieved July 9, 2001, from <http://icc.bcm.tmc.edu/>
- Intercultural Cancer Council. *Asian Americans and cancer*. Retrieved July 9, 2001, from <http://icc.bcm.tmc.edu/>
- Intercultural Cancer Council. *Hispanics/Latinos and cancer*. Retrieved July 9, 2001, from <http://icc.bcm.tmc.edu/>
- Isaacs, R. B., Lobo, P. I., Nock, S. L., Hanson, J. A., Ojo, A. O., & Pruett, T. L. (2000). Racial disparities in access to simultaneous pancreas-kidney transplantation in the United States. *The American Journal of Kidney Diseases*, 36(3), 526-533.
- The Kaiser Family Foundation. (1999). *Key facts: Race, ethnicity and medical care*. Retrieved July 9, 2001, from www.kff.org
- The Kaiser Family Foundation. (1999). *Survey of race, ethnicity and medical care: Public perceptions and experiences*. Retrieved July 9, 2001, from www.kff.org
- The Kaiser Family Foundation. (2000). *Key facts: HIV/AIDS and African Americans*. Retrieved July 9, 2001, from www.kff.org

Lasater, L. M., Davidson, A. J., Steiner, J. F., & Mehler, P. S. (2001). Glycemic control in English vs. Spanish speaking Hispanic patients with type 2 diabetes. *Mellitus Archives of Internal Medicine*, 161, 77-82.

Lee, L. J., Batal, H. A., Maselli, J. H., & Kutner, J. S. (2002). Effect of Spanish interpretation method on patient satisfaction in an urban walk-in clinic. *J. Gen Intern Med*, 17(8), 641-645.

Levinson, W., Roter, D. L., Mullooly, J. P., Dull, V. T., & Frankel, R. M. (1997). Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons. *Journal of the American Medical Association*, 277(7), 553-559.

Like, R. (1998). *Treating and managing the care of diverse patient populations: Challenges for training and practice*. Paper presented at national conference at Center for Health Families and Cultural Diversity, Robert Wood Johnson Medical School, on Quality Health Care for Culturally Diverse Populations: Provider and Community Collaboration in a Competitive Marketplace, New Brunswick, NJ.

Mason, J. (1998). *Rationale for cultural competence in health and human services, training and technical assistance resource manual*. Paper presented at national conference on Culturally Competent Services and Systems: Implications for Children With Special Health Needs, Rio Grande, Puerto Rico.

Mayberry, R., et al. (1999). *A synthesis of the literature: Racial and ethnic differences in access to medical care*. Morehouse Medical Treatment and Effectiveness Center (MMEDTEC). Retrieved July 9, 2001, from www.kff.org

Nelson, K., Norris, K., & Mangione, C. M. (2002). Disparities in the diagnosis and pharmacologic treatment of high serum cholesterol by race and ethnicity. *Archives of Internal Medicine*, 162, 929-935.

Robbins, J. M., Vaccarino, V., Zhang, H., & Kasl, S. V. (2000). Excess type 2 diabetes in African-American women and men aged 40-74 and socioeconomic status: evidence from the third national health and nutritional examination survey. *Journal of Epidemiological Community Health*, 54, 839-845.

Saha, S., Komaromy, M., Koepsell, T. D., & Bindman, A. B. (1999). Patient-physician racial concordance and the perceived quality and use of health care. *Archives of Internal Medicine*, 159, 997-1004.

Schulman, K. A., Berlin, J. A., Harless, W., Kerner, J. F., Sistrunk, S., Gersh, B. J., et al. (1999). The effect of race and sex on physicians' recommendations for cardiac catheterization. *The New England Journal of Medicine*, 340, 618-626.

Schmidley, D. (2003). The foreign-born population in the United States: March 2002. *Current Population Reports*, P2-539. Washington, DC: U.S. Census Bureau.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.) (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Institute of Medicine.

Suro, R. (2000). Beyond economics. *American Demographics*, 22, 2.

Thorne, S. (2001). Reaching the minority majority. *Pharmaceutical Executive*, 21, 4.

U.S. Census Bureau. 1990 Census lookup, summary level: Nation. Retrieved June 19, 2001, from www.census.gov

U.S. Census Bureau. *Projections of the total resident population by 5-year age groups, race, and Hispanic origin with special age categories, middle series*. Retrieved June 19, 2001, from www.census.gov

U.S. Census Bureau. *Overview of race and Hispanic origin from Census 2000*. Retrieved June 19, 2001, from www.census.gov

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. Retrieved March 2, 2003, from <http://www.mentalhealth.org/cre/default.asp>

U.S. Department of Health and Human Services. (1998). *The initiative to eliminate racial and ethnic disparities in health*. (Policy statement). Washington, DC.

For More Information...

For more information on the topics covered in this policy brief, please see the listing of resources below.

TOPIC AREA Eliminating Disparities in the Health Status of People of Diverse Racial/Ethnic Backgrounds

Institute of Medicine. (2002). Guidance for the National Healthcare Disparities Report. Washington, DC. Available at www.iom.edu

The Association of State & Territorial Health Officials and the National Association of County and City Health Officials (2001). *Health Departments Take Action: A Compendium of State and Local Models Addressing Racial and Ethnic Disparities in Health*. Available at <http://www.astho.org/pubs/nabookfull.pdf>

Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review*, 57(Suppl. 1): 181-217.

TOPIC AREA Improving Quality of Services and Health Outcomes

Roizner, Monica. *A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations*. Boston, MA, Judge Baker Children's Center, 1996.

"Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans" 3/6/2002. The Commonwealth Fund, Washington, DC. Webcast available at www.kaisernetwork.org

The Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation. *Opening Doors: Reducing Sociocultural Barriers to Health Care*. Washington, DC, 1997. Available from <http://www.rwjf.org/reports/npreports/opendoorse.htm>

TOPIC AREA Responding to Current and Projected Demographics

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. (2002). *Racial and Ethnic Approaches to Community Health (REACH 2010): Addressing Disparities in Health At A Glance 2002*. Available from http://www.cdc.gov/nccdphp/aag/aag_reach.htm

U.S. Department of Homeland Security, Bureau of Citizenship and Immigration Services. *Fiscal Year 2001 Statistical Yearbook*. Washington, D., 2002. Available from <http://www.immigration.gov/graphics/shared/aboutus/statistics/index.htm>

TOPIC AREA Gaining a Competitive Edge in the Marketplace

The Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation. *Opening Doors: Reducing Sociocultural Barriers to Health Care*. Washington, DC, 1997. Available from <http://www.rwjf.org/reports/npreports/opendoorse.htm>

Betancourt, J. R., Green, A. R., & Carrillo, J. E. (2002). *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*. The Commonwealth Fund. Available at http://www.cmwf.org/programs/minority/betancourt_culturalcompetence_576.pdf

BostonWorks.com has a feature called "Diversity Works" on their web site with information and resources on <http://bostonworks.boston.com/diversity>

Ordering information for specific materials referenced in the above resource list.

A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations

The Technical Assistance Center for the Evaluation
of Children's Mental Health Systems
Judge Baker Children's Center
295 Longwood Avenue
Boston, MA 02115
Phone: (617) 232-8390
Fax: (617) 232-4125

Opening Doors: Reducing Sociocultural Barriers to Health Care: Lessons Learned

Ms. Son Park
Director, Grants and Network Development
HSC Healthcare System
1808 I Street, NW, Suite 600
Washington, D.C. 20006
Phone: (202) 454-1248
spark@cscn.org

NCCC Faculty and Staff who assisted with this Brief

Marisa Brown, Director, BPHC Project

Diane Lewis, Senior Project Assistant

Suggested Citation

Cohen, E., & Goode, T. D. (1999), revised by Goode, T. D., & Dunne, C. (2003). Policy Brief 1: Rationale for Cultural Competence in Primary Care. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.

About the



The mission of the National Center for Cultural Competence (NCCC) is to increase the capacity of health care and mental health programs to design, implement and evaluate culturally and linguistically competent service delivery systems. The NCCC conducts an array of activities to fulfill its mission including: (1) training, technical assistance and consultation; (2) networking, linkages and information exchange; and (3) knowledge and product development and dissemination. Major emphasis is placed on policy development, assistance in conducting cultural competence organizational self-assessments and strategic approaches to the systematic incorporation of culturally competent values, policy, structures and practices within organizations. The NCCC is a component of the Georgetown University Center for Child and Human Development and is housed within

the Department of Pediatrics of the Georgetown University Medical Center. It is funded by and operates under the auspices of Cooperative Agreement #U93- MC-00145-08 and is supported in part from the Maternal and Child Health program (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services.

Funds to develop and publish this Policy Brief were provided by the Bureau of Primary Health Care, Health Resources and Services Administration, Department of Health and Human Services.

FOR ADDITIONAL INFORMATION CONTACT:

National Center for Cultural Competence
Georgetown University Center for Child and Human Development
3307 M Street, NW, Suite 401 • Washington, DC 20007-3935
Voice: 800-788-2066 or 202-687-5387
TTY: 202-687-5503 • Fax: 202-687-8899
E-mail: cultural@georgetown.edu
URL: <http://gucdc.georgetown.edu/nccc>